REPORT OF THE

STATE CORPORATION COMMISSION ON THE ACTIVITIES OF THE OFFICE OF THE MANAGED CARE OMBUDSMAN

TO THE HOUSE COMMITTEE ON COMMERCE & LABOR; THE HOUSE COMMITTEE ON HEALTH, WELFARE AND INSTITUTIONS; THE SENATE COMMITTEE ON EDUCATION & HEALTH; THE SENATE COMMITTEE ON COMMERCE & LABOR AND THE VIRGINIA JOINT COMMISSION ON HEALTH CARE

COMMONWEALTH OF VIRGINIA
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To: The House Committee on Commerce & Labor
The House Committee on Health, Welfare and Institutions
The Senate Committee on Education & Health
The Senate Committee on Commerce & Labor
and
The Virginia Joint Commission on Health Care

The report contained herein has been prepared pursuant to § 38.2-5904 of the Code of Virginia.

This report documents the activities of the Office of the Managed Care Ombudsman for the reporting period covering November 1, 2002, through October 31, 2003.

Respectfully Submitted,

Commissioner Hullihen Williams Moore
Chairman

Commissioner Theodore V. Morrison, Jr.

Commissioner Clinton Miller

Report on the activities of the Office of the Managed Care Ombudsman

Executive Summary

This annual report on the activities of the Office of the Managed Care Ombudsman ("Office") covers the period from November 1, 2002, through October 31, 2003. During this time, the Office assisted approximately 1,000 consumers whose health insurance is provided by a Managed Care Health Insurance Plan ("MCHIP"). The Office provided general information, responded to specific questions from consumers, and assisted individuals that wanted to appeal an adverse decision their MCHIP issued denying a service or a claim. The Office continued its outreach and educational efforts to help consumers understand the benefits available from their MCHIP and provided tools to assist consumers in resolving problems. When applicable, consumers were referred to other regulatory agencies for assistance. We conclude that the Office continues to provide a valuable resource for consumers whose health insurance is provided by a Managed Care Health Insurance Plan.

In accordance with § 38.2-5904 of the Code of Virginia, the Office of the Managed Care Ombudsman (the "Office") was established in the State Corporation Commission's Bureau of Insurance ("Bureau"). This report is submitted pursuant to § 38.2-5904 B 11, which requires that an annual report be submitted to the standing committees of the Virginia General Assembly having jurisdiction over insurance and health and also to the Joint Commission on Health Care. This is the fifth annual report and covers the period from November 1, 2002, through October 31, 2003.

As reflected in the previous annual reports, the Office was established and functional as of July 1, 1999, as required by legislation that the General Assembly passed to create the Office. Since that time, the Office has continued to accomplish its responsibilities and meet its objectives as set forth in the legislation that created the Office.

During its fifth year, the Office emphasized its two key functions: providing information in response to inquiries from consumers and formally assisting consumers in appealing adverse decisions rendered by their Managed Care Health Insurance Plan ("MCHIP"). Inquiries are classified as a question or a general request for information or assistance that can be answered directly by the staff. Inquiries are processed informally and include telephone calls, e-mails, and correspondence. During the previous reporting period of November 1, 2001, through October 31, 2002, the Office responded to 1,936 consumer inquiries; and during the current reporting period, the Office responded to 778 consumer inquiries, a decrease of 60%.

During the previous reporting period, the Office provided formal assistance to 257 consumers who wanted to appeal an adverse decision made by their MCHIP. During the current reporting period, the Office provided formal assistance to 210 consumers who indicated they wanted assistance in appealing an adverse decision made by their MCHIP. The decrease in the number of consumers seeking assistance may be in response to changes that some of the MCHIPs have instituted in their appeal process, which eliminated a second opportunity to appeal an adverse decision if the first appeal was denied. As required by the legislation that established the Office, the Office asks the consumer to complete and sign an authorization form when this type of assistance is provided. This form documents the individual's consent for the Office to help the person in the appeal process. Once the Office obtains the consumer's written permission to provide assistance, staff assists the consumer in navigating the internal appeal process with his or her particular MCHIP, offers suggestions for an effective appeal, contacts the MCHIP to ensure that the appeal is considered, and assists in clarifying disputed circumstances and facts regarding the appeal.

If the MCHIP renders a favorable decision on an appeal, the Office closes the file. For those consumers whose appeal is denied, the Office provides assistance in filing a second appeal, if available. When an MCHIP renders a final adverse decision, the staff provides information on applicable alternatives, including referrals to the External Appeal program conducted by the Bureau, offers a referral to another section in the Bureau, or to another regulatory agency. In some instances, once the consumer completes the internal appeal process, there are no further alternatives.

The Office redesigned the authorization form this year after staff had observed that many consumers who initially contacted the Office for assistance with an appeal did not return the form. The objective was to make the form more consumer-oriented while still capturing the basic information the Office would need to help the consumer with an appeal. It is too early to determine if this project has accomplished its objective.

As reflected in previous annual reports, the Office has continued to encounter many consumers whose problems with their MCHIP appear to be due to the consumer's own lack of understanding as to how health insurance works. One of the most common problems encountered is that many consumers do not understand that their MCHIP is only required to provide the benefits and services stated in the policy and Evidence of Coverage ("EOC"). The Office has made a concerted effort to help consumers realize that not every medically necessary service or treatment is eligible for coverage under the terms of their health insurance coverage. Further, the Office tries to help consumers understand that some services and benefits, although authorized, are subject to contractual duration limitations. The Office continues its educational efforts to help consumers develop functional knowledge regarding health care benefits so they can readily apply this knowledge to both understanding their own coverage and to utilizing fully the benefits available to them.

The Office continues to maintain sample copies of EOCs used by the MCHIPs that conduct business in Virginia and uses this information to assist consumers in responding to inquiries or moving forward with appeals. Many MCHIPs have informed the Office that its efforts to educate consumers and help them understand the information in the EOCs compliments the MCHIPs' efforts to help their enrollees understand available benefits. There were numerous instances when an enrollee discovered, after speaking with Office staff, that the information provided by the MCHIP regarding the individual's available benefits was correct, so the individual understood that an appeal would not be productive. This scenario frequently occurred with enrollees who intended to appeal a denial their MCHIP had made based upon the fact that the requested service was a specific non-covered benefit as clearly stated in the EOC.

The Office took advantage of several opportunities to provide or participate in outreach programs and to provide brochures and other consumer publications for the booth staffed by the Bureau at the Virginia State Fair and other similar civic functions. Staff met with a group of consumers in Northern Virginia and provided information to assist parents whose children require special needs, such as speech therapy and physical therapy. The Office also met with the Patient Advocate Foundation, a nonprofit organization that assists patients with insurance and health-related issues, and formed a working relationship whereby each organization may exchange referrals in appropriate circumstances. The Office also forged a working relationship with the Virginia Department of Agriculture's Office of Consumer Affairs, which helps consumers resolve disputes with many types of businesses. This relationship enhanced the ability of each office to redirect consumers to the appropriate agency for assistance. Staff participated in a health fair conducted in Richmond and provided consumer information to the attendees. The Office was mentioned in articles featured by The Washington Post and Richmond Times-Dispatch that addressed difficulties confronted by some consumers covered by managed care.

During this reporting period, the Office expanded the number of publications it offers to consumers. The Office published a tip sheet containing suggestions to help consumers make effective appeals and also published a tip sheet designed to assist parents of children with special needs. This tip sheet was developed in response to a need identified after staff conducted an outreach program. The Office also constructed a simple flow chart to help consumers understand the multiple steps involved in making an appeal. The chart was specifically designed to help consumers visualize the process since some consumers may better understand information presented in graphic form. All of this information was posted on the Office's pages on the Bureau's Internet web site, in addition to being available in printed form for mailing and outreach appearances.

There were 8,379 visits to the Office's pages on the Bureau's Internet web site during this reporting period, which is a 34% increase from the 6,233 visits during the previous reporting period. This increase may explain why the number of inquiries was less than the number of inquiries last year since consumers may now obtain answers to many of their questions and concerns from the information posted on the web site, thereby reducing the need for contacting the Office by telephone, e-mail, or correspondence. Feedback from consumers indicates that the information on the Internet is not only helpful but easily accessible and available virtually anytime that an individual is online. By continually expanding the topics and subjects addressed on the web site, the Office was able to provide a greater variety of information to an increasing number of consumers.

In conjunction with the Virginia Department of Health's Center for Quality Health Care Services and Consumer Protection (the "Center"), the Office received and reviewed the required annual complaint report that each MCHIP is required to

submit. The report, which is required to be submitted to both the Office and the Center, reflects the number of complaints that an MCHIP received during the calendar year. The review indicated that, as in previous years, the ratio of MCHIP enrollees who file a complaint to the total number of MCHIP enrollees is very low, although it in no way diminishes the severity of problems that a very small number of enrollees have encountered with their particular MCHIP.

The Center and the Office coordinated their efforts to assist consumers, and the Office referred consumers who expressed dissatisfaction with the quality of care their MCHIP provided to the Center for assistance. Under Virginia statute, the Center exercises regulatory jurisdiction over the quality of care provided by MCHIPs. Some of these referrals involved consumers whose MCHIP did not have a physician readily available in their network capable of providing medical care that the patient required. The Office also referred cases to the Center that concerned appeals when an MCHIP's clinical criteria were questionable so that the Center could review the clinical criteria under the applicable statute.

In the course of assisting consumers of one MCHIP with appeals involving surgical procedures and diagnostic testing during the past year, the Office noted that the MCHIP issued a few final adverse decisions based upon a contractual exclusion in the individual's policy and not because the MCHIP determined the requested services were not medically necessary. Office staff believed the appeals involved issues of medical necessity and were not strictly contractual denials. Since contractual denials are not subject to the External Appeals program administered by the Bureau, the Office discussed the denials with the External Appeals section who contacted the MCHIP for additional information. As a result, the appeals were reconsidered and accepted by External Appeals and, subsequently, were overturned in favor of the enrollees.

The Office continued to work with the legislative staffs of various members of the General Assembly and, in some cases, directly with members to assist constituents who encountered problems with an MCHIP. Depending upon the nature of the problem, the Office was able to either provide direct assistance to the consumer or refer the consumer to another agency for assistance. The Office also responded to general questions from members and their staffs regarding issues related to managed care.

During this reporting period, the Office received and reviewed 10 complaint system filings submitted by MCHIPs. These filings describe how the MCHIP administers its complaint, grievance, and appeal systems; and these filings must be approved by both the Office and the Center. The Office approved 8 filings once it was determined the filings contained all of the information required by the governing statutes and regulations, and 2 are still under review. In addition, staff initiated reviews of 19 MCHIP complaint systems filings after noticing potential problems with some aspect of how certain MCHIPs had processed appeals or when the Office had not been provided a current copy of an MCHIP's complaint

system. These reviews resulted in 10 MCHIP complaint systems being approved, with 9 currently pending. In all of the reviews, staff ensured the contact information about the Office is contained in correspondence MCHIPs send to enrollees in the appeal process. Staff believes it is important that this information is clearly stated to ensure enrollees who receive correspondence regarding an appeal know that the Office can assist them and also know how to contact the Office.

We do not have any comments on legislation enacted at the national level during this reporting period. As noted in the previous annual report, the U.S. Department of Labor had issued a new regulation affecting the appeal procedures employed by some MCHIPs in Virginia. Since the regulation specified certain time limits that health plans could use in deciding appeals and notifying consumers of the outcome, some MCHIPs have reduced the number of appeal levels from two levels to one level. By offering one appeal instead of two appeals, an MCHIP could comply with the reduced timeframes to reach and then issue a decision. Experience during this reporting period confirms the observation made in last year's annual report that this reduction adversely affected enrollees whose first appeal lacked sufficient information to be effective, since there was no opportunity for an additional enrollee appeal. Partially in response to this concern, the Office developed the consumer tip sheet on how to make an effective appeal so that consumers with only one opportunity to appeal could have information to assist them in maximizing the effectiveness of their appeal effort.

We are monitoring legislation that Congress is considering regarding Association Health Plans ("AHPs"), which would enable small businesses to purchase health insurance collectively for their employees. While there may be some benefits to AHPs, these plans would not be required to be licensed at the state level, and state insurance laws and regulations regarding financial solvency and coverage of certain benefits would not apply to these plans. Consequently, consumers insured under AHPs would not be protected under state insurance laws; and if problems occur, consumers would not be able to obtain assistance from state regulators.

Legislation prohibiting re-underwriting of health insurance coverage that was enacted in Virginia this past year will assist consumers whose coverage is provided in the individual health insurance market as well as consumers whose coverage is provided through group health insurance. Other legislation enacted affects basic health or health coverage and allows essential and standard plans offered in the small group health insurance market in Virginia to be exempt from health insurance mandates and certain other statutory requirements regarding classes of providers. We believe this legislation also affords benefits to Virginia consumers.

In summary, during this reporting period, the Office has continued to function in accordance with the design and intent of the legislation by which it was established. The Office assists Virginia consumers and helps consumers resolve problems with their MCHIP that otherwise would not be solved, which is an integral part of the consumer assistance programs conducted by the Bureau of Insurance.